Some Practical Considerations about the Vitamins

By PROFESSOR A. BRUCE MACALLUM

At present three elements can be be classified definitely under the above heading: the fat soluble or "A" factor, associated with butter, cod liver oil and green leaves of vegetables; the water soluble "B" compound found in milk, bran flours, cereal grains and vegetables; the antiscorbutic "C" substance present in fresh vegetables, the juices of citrus fruits and juices of the suede turnip. These vitamins tend to deteriorate during prolonged periods of storage, through the action of food preservatives, and as a result of heating agencies. Heating for over an hour at the temperature of boiling water, or steam pressure sterilization for this period, will cause food stuffs subjected to these processes to display a demonstrable diminution in their vitamin content. As these so-called "accessory factors" are only a microscopic fraction of the total mass of food materials, attempts to isolate them in a pure state, in quantities requisite for analysis, have proved as yet unsuccessful. The sole method of detection or determination of the degree of activity of these compounds is through feeding experiments upon fowls, rats or mice with the foodstuffs under consideration. These essential factors must be present in the ration for the maintenance of health and life; consequently when the food intake is deficient in respect to these, well defined pathological syndromes follow, known as deficiency diseases or avitaminoses. These appear in both the acute and chronic types, the latter being the result when the deficiency is not absolute but insufficient to maintain the normal level for prolonged periods.

The acute deficiencies are not met in local practice, with the exception of infantile scurvy, since the population is on a relatively high economic level and has access to a varied selection of food-stuffs. A generation ago even the chronic forms were seen only at very rare intervals, because the preparation of food-stuffs from the products of the soil and herd was entirely domestic. Farmers ground their own grains or had them converted into flour in simple types of mills, so that the flours possessed a high bran and mineral content; cattle were slaughtered on the farm and all the meat products used for immediate consumption. The vitamin fraction suffered little by the use of these primitive methods of converting the crudes into edible materials and negligible quantities were lost in refining the cereals. Today the food industry is highly specialized and on a commercial basis, requiring a large capital investment in plant, storage capacity and transportation facilities; the conversion of large areas into the production of special lines of agricultural products for economic reasons has abolished the self-contained local character of the food industry; while the manufacture of dietetic articles tends toward the production of materials capable of storage and requiring little domestic preparation. The demand for staples of the latter class has led to the production of packaged articles in which the essential qualities are largely deleted by the sacrifice of certain parts to satisfy the aesthetic taste of the consumer or for the pur-

pose of enabling the manufacturer to give the capacity to withstand long periods of storage. Flours are milled to the point where the vitamin fraction of the original grain goes almost entirely into the miller's by-products, and bleaching and chemical treatment practically eliminates the residue. Meat products are stored for weeks and even months, treated with chemical preservatives and sterilized under conditions which partially destroy the essential dietary qualities. The present-day tendency in increasing the consumption of starches and sugars, associated with a lowered vitamin intake in the total food mass, tends to bring about a mild deficiency, since one of the functions of these compounds is to help maintain an increased sugar tolerance.

The primary function of the accessory compounds is that of keeping the mucous membrane of the intestinal tract in a healthy condition, thus maintaining intact the barrier against the entrance of intestinal organisms into the system and ensuring the copious production of the digestive secretions. The digested material is consequently readily absorbed from the lumen of the gut, the musculature is maintained in good tone and the residues are rapidly passed on by peristaltic action and promptly ejected. Experiments on animals in which the effects of a chronic mild vitamin underfeeding have been produced demonstrate that there results a dilated atonic intestinal tract in which the mucous membrane has degenerated, become atrophied and eroded in patches. The resistance against intestinal organisms has declined and they are enormously increased in numbers, invade the glands and often gain direct access to the blood stream from the ulcerated wall of the intestine. There is a tendency to formation of ulcers and the dilated atonic bowel cannot force along or expel the residue with any power or regularity. Assimilation becomes faulty and the whole system suffers. The dominating symptoms which appear in such a condition are "dyspepsia" and "constipation," a syndrome which seems to be common if one may judge from the flood of proprietaries advertised for these conditions. The remedy in these cases is not to be found in drugs, which only aggravate the atonic condition of the intestinal tract, but in an adequate vitamin supply, such as raw fresh vegetables, fruit, milk and whole wheat breads. But even in this treatment immediate relief is not to be expected since the intestinal condition is the result of months or years of faulty diet and benefit can only be attained by persistent dieting of an adequate quality carried over a long period.

Rickets has been considered as a result of a vitamin deficiency for the past few years. It has always been associated with living conditions where the incidence of sunlight was low. Recent research has proved that the lime and phosphorus deposition in the bone which is deficient in such cases is controlled by the ultra-violet portion of the solar radiation or radiation from any artificial source which is rich in these rays. The antirachitic properties previously ascribed to dietary factors were due to the fact that the food-stuffs have acted as carriers of these rays into the system, and any article of the ration can be made antirachitic by subjecting it to ultra-violet radiation from some artificial source. The coat of tan acquired by exposure at summer resorts and golf courses is a certificate of sufficiency of a supply of these rays, as the burning and tanning effect is produced by this portion of the sun's rays—which is the tonic factor. The therapeutic element of sunlight does not penetrate window glass, so that children brought up where the incidence of sunlight is

(Concluded on page 470)

— Editorials —

With this issue the Canadian Nurses' Association enters its tenth year as owner and publisher of The Canadian Nurse.

It was at the fifth general meeting of the Association, held in Winnipeg in June, 1916, that the representatives of the federated associations in convention assembled, by an unanimous vote, decided to purchase The Canadian Nurse and to have it published as the official organ of the National Association.

At the twelfth general meeting, held in Hamilton in June, 1924, by a large majority vote, the delegates expressed the wish to have The Canadian Nurse published from the National Office. Following this decision the executive committee appealed to the federated associations to make a special effort to gain a large increase in subscribers among the nurses in the Dominion. A comparative table showing the percentage of subscribers in the provincial associations appears on the next page. These percentages are based on the paid-up membership in the provincial associations for the past two years and the number of subscribers appearing on the mailing list for August, 1924-1925.

Congratulations are due the members of the association in the "baby" province of the Dominion as the figures for that province show that at present 55 per cent. of the members are subscribers. Congratulations are also due the provincial association in Manitoba, which shows the greatest percentage increase in subscribers during the past year. While the records show that there has been no increase in the membership of the Canadian Nurses' Association as represented by the total membership of the provincial associations the subscription list for the magazine shows an increase of almost 40 per cent. Unfortunately this increase is not as favorable as it at first appears: it has been found that for every two new names added to the subscription list for the provinces, one expiry has failed to renew. There may be various reasons for so many failing to renew their subscriptions, but it is felt that the majority have been allowed to lapse through forgetfulness or procrastination. In a very few cases it may be owing to financial stringency, and possibly a few may have allowed other reasons to influence their actions.

It might be well for us to recall the time and ability that have been given to the support of our magazine by the officers of the association and by a few members in contributing to the continuance of the magazine; the former also having had the anxiety connected with the financial management of our publication.

Space does not allow us to recount much that has been done by the few, but we would like to remind the members of the federated associations that we owe a debt of gratitude to our officers and contributors. There are various means by which the appreciation of the majority might be expressed to our officers and contributors. The purpose of this article is to urge every subscriber-member to aid the circulation manager of her association to obtain many new subscriber-members during the next three months. Let us make the last quarter of 1925 memorable to The Canadian Nurse and to Canadian nurses as the time when every member of each provincial association became a subscriber to our national magazine.

This is not asking too much of our nurses—if we stop to realize that when one is not a subscriber or is not making an effort to obtain new subscriptions whenever an occasion presents itself we may well be regarded as adverse critics of the members of our executive committee and of our contributors.

Nature may have equipped a few nurses so that they are insensitive to criticism, but it is felt that many are so sensitive to criticism of their best and voluntary efforts in furthering the interests of our profession that it requires infinite courage from them to continue in provincial and national work.

Do we honor members by electing them to office if we promptly neglect —or forget—to do our share in the development of our respective associations and in the maintenance of our official organ—The Canadian Nurse?

We do know that The Canadian Nurse needs every member as a subscriber—and may we add, "every member needs The Canadian Nurse?" May the first months of our tenth year be long remembered as the time when we threw ourselves whole-heartedly into the campaign: EVERY NURSE A SUBSCRIBER TO HER NATIONAL MAGAZINE!

REPORT OF INCREASE IN THE CIRCULATION IN CANADA OF THE CANADIAN NURSE: AUGUST, 1924—AUGUST, 1925

	Subscribers: Aug., 1924	Subscribers: Aug., 1925
Alberta	23.0% of membership	23.0% of membership
British Columbia	18.3% "	18.3% "
Manitoba	22.2% "	48.0% "
New Brunswick	22.6% "	30.8% "
Nova Scotia	23.7% "	17.1% "
Ontario	28.9% "	38.0% "
Prince Edward Is.	12.5% "	8.6% "
Quebec	11.9% "	20.3% "
Saskatchewan	27.8% "	55.5% "

We wish we could have the pleasure to say in person "Welcome home" to those Canadian nurses who are returning after their trip abroad and attendance at the Congress in Helsingfors. While the official report of our representatives is not yet available, we are able to announce that Canada was well represented at the Congress—representatives were present from our private duty nurses, our public health nurses, our training schools—large and small—and the departments of nursing in our universities. We shall look forward to an increased enthusiasm in our nurses' organizations after so many having been privileged to meet and mingle with our sister nurses from other countries. Miss Nina Gaga, China, was elected president of the International Council of Nurses, while Miss Clara Noyes, United States, was elected first vice-president, and Miss Jean Gunn, Canada, second vice-president.

We are very pleased to have this opportunity of offering our congratulations to Miss Gunn, who is superintendent of nurses in the Toronto General Hospital. From 1914 to 1917 Miss Gunn was secretary of the Canadian Nurses' Association, and from 1917 to 1920 she was president of the same organization. No nurse in Canada is more widely known and greatly admired for her ability, or more sincerely appreciated for her contribution to the nursing profession, and we know that our nurses throughout the Dominion are delighted that such an honor has been conferred on Miss Gunn.

Our readers will be interested to learn that Miss Mabel F. Gray, honorary secretary of the Canadian Nurses' Association since 1922, has been appointed to succeed Miss Ethel I. Johns as assistant professor of nursing at the University of British Columbia. Prior to entering the Winnipeg General Hospital, Miss Gray obtained the first class teachers' diploma. She graduated from the Winnipeg General Hospital Training School in 1907. From her graduation and until 1914 Miss Gray held the positions of ward supervisor, instructor of nurses, and assistant superintendent in her alma mater. In 1914 she was appointed superintendent of nurses, and resigned in 1919 in order that she might take the one-year course in Public Health Nursing, Simmons College, Boston. Miss Gray was appointed organizer and supervisor of Nursing Housekeepers in the province of Saskatchewan in August, 1920, and resigned from that position to accept her new appointment. She has been secretary and registrar of the Saskatchewan Registered Nurses' Association since 1920.

Our heartiest congratulations are offered to Miss Gray, and she assumes her new duties, for which she is so admirably fitted, with our best wishes for continued success in the nursing profession.

Isabel Maitland Stewart

A Biographical Note

Isabel Maitland Stewart was born in Ontario, but at a very early age came with her parents to Morden, Manitoba. She is a graduate of the Winnipeg Collegiate Institute and of the Manitoba Normal School, and taught four years in the public schools of Manitoba before entering the Winnipeg General Hospital for training in 1900.

Subsequent to graduation she engaged for a short time in private nursing and for one year served in the capacity of ward supervisor in the Winnipeg General Hospital.

In 1908 she enrolled as a student in the Department of Nursing and Health in Teachers' College, Columbia University. After one year of college work she became part time assistant to Miss Nutting; continuing her academic course at the same time. She received her Bachelor of Science degree from Columbia in 1911 and her Master's degree in 1913.

In 1917 she was appointed assistant professor and in 1923 associate professor. In 1925 she was appointed professor in succession to Miss Nutting, whom she had so ably assisted for sixteen years.

Her chief interest possibly lies in the task of preparing teachers for Schools of Nursing. She has been chairman of the Education Committee of the National League of Nursing Education for some years and recently assumed the chairmanship of the Committee for the Grading of Nursing Schools.

In addition to numerous pamphlets and articles she has written in collaboration with Miss Dock, 'A Short History of Nursing.' This volume remains the best text which has yet been published on this interesting subject.

In addition to her other gifts, Miss Stewart is an accomplished and delightful public speaker and has been much in demand at hospital and nurses' conventions.

Possibly no woman living, except Miss Nutting herself, has made as great a contribution to the cause of nursing education as Isabel Stewart. That she was able to do so was not due only to her brilliant intellectual attainments, but also to those sterling qualities of courage and moral steadfastness which have made her what she is.

Her future career will be watched with affection and interest by nurses in every part of the Dominion.—E. J.

The Children of Unmarried Parents

By MRS. J. B. McGREGOR

As this title affords considerable latitude and it is necessary to keep the discussion within reasonable bounds it has been limited to a description of public opinion in Canada on the problem of illegitimacy as it has been expressed, first, by legislation and, second, by the treatment of mother and child.

Without attempting an historical review of the legal aspect of the subject it might be helpful to hold before our vision for a few moments something which represents the essence of our original Canadian law, merely as a background against which to throw a picture of our present-day legislation.

This matter has always been under provincial jurisdiction, all of the provinces inheriting the principle of the old English common law which was originally designed not to benefit the mother or child but merely to protect the titles and rights of propertied classes. At a later period the principle of making a claim on the father was introduced on the complaint of certain poor-law officials of the heavy drain the support of these children made on the public funds.

With the exception of Quebec, where there seems to be no definite statute on the subject, this old law formed the basis of all the early legislation, with slight variations in the different provinces, usually under the objectionable title "The Bastardy Act," also inherited from England. In every case the emphasis was on the reimbursement of funds and not on the maintenance of the child and the only remedy to enforce it was a suit brought against the father by anyone who had furnished the necessities of life for the child.

The inadequacy of these old acts is illustrated by a study made of the cases handled by one Toronto organization in 1920. It was found that in less than 10 per cent. of the cases had the father made any contribution towards the expenses of the mother or child even to the extent of a few dollars and less than 1 per cent. were making any attempt to maintain the child.

These facts taken in conjunction with the approximate annual illegitimate birth-rate of 1,000 in Toronto alone would indicate the enormous burden which was being carried by public and private charity and often by incompetent mothers hardly capable of properly supporting themselves, while so many of the fathers were entirely relieved of all responsibility. But the fact that the death-rate among illegitimate children was more than twice as high as that of normal children, and many other significant facts, furnish abundant proof that the burden was ultimately and inevitably borne by the innocent child. It meant that all his life, in addition to the stigma of his birth, he must carry a frail body and weakened constitution.

As far as legislation to remedy this injustice is concerned there was no evidence of any righteous indignation on the part of the public for a great many years except that the liability for admitted responsibility was increased from time to time in certain provinces where a stated amount was named. Then, in 1920, Saskatchewan and Prince Edward Island passed acts legitimating the child by the subsequent marriage of the parents, which had previously applied only in Quebec. Similar acts are now on the statute books of all of the nine provinces. But the principle of demanding permanent and adequate maintenance of an illegitimate child by its father was first introduced into Canadian law in the Act for the Protection of Chil-

dren of Unmarried Parents passed in Ontario in 1921. Similar legislation has subsequently been passed in four other provinces and is under serious consideration in at least three of the others.

As the Ontario act has been in force a little longer than the others it forms the best basis of study and we shall consider it in detail, remembering that it is now law also in Manitoba, Alberta, British Columbia and Prince Edward Island. This act deals entirely with the economic aspect of the question and is not in any way punitory. The moral or immoral behaviour of the parents is not considered at all except in as much as it constitutes evidence of paternity or disqualifies the mother as a proper guardian of her child.

The act provides for an officer known as the provincial officer to have charge of its administration, and provision is made for the division registrar to report to him all illegitimate children registered under the Vital Statistics Act and every birth so registered as to suggest that the parents were not married. The mother may apply to the provincial officer for advice or assistance or he may take the initiative and institute proceedings as he thinks necessary in the interest of the child. The provincial officer may himself be appointed guardian of the child either alone or with the mother and at any time has power to deal with the child as a neglected child under the Children's Protection Act.

Affiliation proceedings may be started by the mother or anyone acting in her interest, and during the lifetime of the father. The time limit is within a year of the birth of the child, or within a year of the doing of any act on the part of the putative father which constitutes evidence of paternity, or, if he has been absent, within a year of his return to the province.

Material evidence is necessary to corroborate that of the mother and upon sufficient evidence the judge makes an order on the father in accordance with his ability to provide. The order having been made, the father may be required to furnish security, and upon his failure to do so he may be committed for contempt of court.

The liability of the father covers the confinement expenses of the mother, her expenses for three months preceding the child's birth and as long after as is considered advisable in the interest of the child. It covers the maintenance of the child for sixteen years and may also include the burial expenses of the mother should her death result from childbirth, or the expenses of the burial of the child. In case of the death of the father after an order has been made, such an order shall bind his estate, but provision is made to protect first the interest of the legitimate wife and children.

The expenses of the administration and enforcement of the act are paid out of the revenue of the province. All litigation arising out of the act shall be tried by a judge of the county or district court, including a police magistrate, or a judge of the juvenile court, and all hearings are in camera.

For the most part these acts have passed with the strong support of the entire thinking public and there has been little demand for any change in principle. It is very generally realized, however, that uniformity in these laws is something very much to be desired and also some reciprocal arrangement between the provinces for bringing the absconding parent to justice.

Prince Edward Island is the only province so far that has succeeded in passing the dual paternity clause. This provides that where there are two or more possible fathers the responsibility shall be divided among

them, and is valuable not so much for the extra money that might be secured in this way but because it meets the defense so often made by the man, of promiscuity on the part of the woman. It is to be hoped that this clause will ultimately be embodied in the laws of all the provinces. Likewise the provision in the Manitoba act for the reporting direct to the provincial officer by maternity hospitals any births which appear to be illegitimate.

This legislation has not been long enough in operation to furnish any material for an exhaustive study, but the provincial office in Ontario and some of the organizations handling the greatest number of cases have provided some interesting statistics. Since the act came into force over $100,000 has been collected, and of this over $60,000 was during the last year. Over 1,000 children are now benefitting under the act by regular payments of $20 to $25 a month.

With regard to the disposition of the children dealt with, 4 to 5 per cent. have died, 4 per cent. have been legally adopted, 2 per cent. placed in temporary foster homes, 4 per cent. wards of the Children's Aid Society, and 83 per cent. are with the mother. Of the cases closed without a financial adjustment being made, 19 per cent. dismissed for lack of corroborative evidence, in 10 per cent. the couples married, and in 42 per cent. the man disappeared. Several organizations report that the payments are about equally divided between the lump sum and the weekly payment basis and that the average lump sum payment is about $300.

We all realize that the success of this act depends largely on the administration, and as the act becomes better understood and the authorities administering it are better equipped, we hope to be able to make a better showing than this. Some of these figures are significant in illustrating the difficulties of administering legislation of this kind when for the most part we are working with such very poor human material. But generally speaking, the act is benefitting the girl who most needs it, that is, the girl who is willing and able to care for her own child and who is without other resources. Furthermore, we are confident that many cases are now coming to light which would otherwise have remained hidden, and that the children are receiving better care.

Coincident with these changes in legislation we find the same gradual development toward improved methods of care adopted by those dealing with the unmarried mother and child. In all stages and phases of this work in the past the disapprobation of society has been manifested by more or less harsh punishment and relentless ostracism.

Passing over the period in which the unmarried mother was subject to aggressive public humiliation we shall begin with a consideration of the first attempt at handling the problem in a more or less humane way. We find that this has usually taken the form of the establishment of the old-fashioned maternity home. Most of us have become only too familiar with this type of institution, not from our own experience, but perhaps from our memories or the memories of our parents.

We know the large prison-like building surrounded by the high wall and the "Rescue Home for Fallen Women" or some such damning appellation emblazoned in large letters over the door, the degrading uniforms and the smell of laundry and disinfectant, the herding together of the innocent young girl and the hardened prostitute, the healthy in mind and body with the diseased and feeble-minded. The practice was often common of having every new applicant paraded be-

fore the board and made to tell her story under a gruelling examination. The only relief from constant drudgery would be religious meetings of a very emotional nature where the girl's sin was kept ever before her. For a whole year she would live in an atmosphere calculated to rob her of her self-respect, the very basis of regeneration. Then, without her baby, separation from her child being the reward she had won, she was sent out and forgotten, her last state infinitely worse than her first.

Part of the work of many of these institutions consisted in the running of a baby farm on a large scale, which often developed into a profiteering scheme of the worst sort. Wealthy families would pay to have babies taken and no questions asked. Payments were often made also by adopting parents who would take the attractive children. The fate of the other children would be explained by the enormous death-rate, a death not only countenanced but often augmented by deliberate neglect. It is difficult to understand how such a hideous system could be conceived by kindly and well-meaning people but no doubt it was an improvement on what had prevailed before, and even such an attitude is certainly preferable to that which prevails among many people today who prudishly refuse to recognize the existence of the problem because the subject is objectionable to them. Progress can come only through education which is a result of. an intimate knowledge of the subject and in many cases we find some of the chief supporters of the old scheme among the instigators of something far better.

For the sake of contrast, let us consider the spirit which has created one of our most modern maternity homes, a home-like building, beautifully situated, with a capacity for twenty selected girls. Under a name that carries no stigma it was dedicated within the last few weeks and described as "A rest home for the help and recovery of God's children in need, where young women who have suffered wrong may receive strength, friendship, and refreshment." That description with all that it implies is not over estimating what the girls do actually receive while under that roof, and long after they leave it.

Between these extreme types we find in different parts of the country maternity homes in every stage of development. Unfortunately many of the evils represented by the former still exist in our midst in some modified form.

The first step in their reform came with the rigid enforcement of public health laws. With this came the greater appreciation of the sacredness of human life and was expressed in such advanced methods as the placing of children in private boarding homes, the keeping of young babies with their mothers, and the employment of trained case workers.

But the organizations that have had the best opportunity of practising modern methods are those that have been recently organized apart from any institution. Of these the Women's Directory of Montreal is typical. Such organizations have been best able to develop the technique of their work unfettered by the prejudices and complications that grow up with most institutions. During the last few years there has been a very general realization of the necessity of more individuality in treatment, and a consequent improvement in all phases of the work.

In discussing methods it is impossible to deal with more than one aspect of the question, so we shall confine ourselves to the one which always seems the most acute—the question of the separation or the keeping together of the mother and child.

As applied to the nursing period, practically all workers are now unanimous in theory as in practise that the separation should take place only in very exceptional cases. The principal opposition to this comes from the occasional family physician of the old school, but as it is generally realized that the doctors in such cases are not aiming to benefit either the mother or child, but merely to please the person who pays his bill, usually the girl's father, his point of view is hardly worth considering.

There is more difference of opinion regarding the permanent problem after the nursing period is over. Many of us who may at one time have had in the back of our minds the idea that, given adequate financial support, it was a comparatively simple undertaking for an unmarried mother to keep her child, now realize that it is never simple, always difficult, and often very dangerous. While we realize that every case must be decided on its own merits, there are certain fundamental considerations which apply to all.

Here again we shall have to be limited and shall deal only with the girl who is capable and desirous of being a good mother to her child, and who is assured of permanent and adequate financial support

We feel that is a mistake to assume that there is necessarily a clash of interest between the mother and child and that the interest of one must be sacrificed for the other. In the very nature of things they are so a part of each other that there is always something very sacred and fundamental violated in their separation. This is realized by the mother from the very beginning but not always by the child until maturity, but then with increasing intensity as the years pass. In the final analysis the mother and child can give to each other something that no one else in the world can give to either of them. It is therefore with a very great sense of responsibility that the social worker approaches the difficult task of trying to advise the mother in making this great decision.

The good worker will not look on her client as something foreign to herself, whose perplexities she cannot understand, but will try to meet her on some common ground. We must know that, whatever her decision, she has a very hard road to travel and that no matter how carefully supervised, she must, like all of us, fight her worst battles alone, her only defense being the strength of character that has been built up within herself. If we feel that one's powers of resistence are sthrengthened not by shirking one's responsibilities, but by accepting them, particularly those that are the natural consequence of one's own actions, are we helping the girl by urging her to give up her child?

In some cases it may be so, but then we must realize that the girl must be fortified in some other way. Furthermore, we must realize that the biggest thing in her life, that intense passionate human affection, cannot be suddenly withdrawn without creating a vacuum which must be filled by something else either helpful or otherwise. Failure to realize these needs has constituted one of the greatest weaknesses in our case work. If, on the other hand, the girl decides to keep her baby we must not underestimate the difficulties in her way. Time will permit merely the suggestion of some of the most obvious of these.

First, with regard to the girl who has her baby with her, it is inevitable that she should suffer, more or less, from what psychologists might call a complex of inferiority. She always feels that she is scorned by her friends and associates and it is hard for her to rise above that and be her best. Then the presence of the child seems to brand her as a target for the compromising approaches of un-

scrupulous men, such insults often coming from quarters where she should be considered safest from that sort of thing. This danger is accentuated by the fact that she almost invariably has a desperate desire for marriage on almost any terms as her only means of gaining respectability.

Another hardship of which the married mother knows nothing is the fact that she is constantly haunted by the horror of the stigma being attached to her child. This thought brings to my mind the image of one of these girls who, in fighting her battle against fearful odds, incurred the displeasure of a neighbour. The neighbour retaliated by calling her baby a "bastard," and the expression of anguish on that mother's face is something that, once having seen it, one can never forget. Sometimes a successful plan is arranged whereby the girl's family absorbs the child and moves to a strange place. Or the girl may masquerade as a married woman, but although this is not illegal and may not be unethical in itself, it seldom seems to work out satisfactorily as a permanent arrangement. It usually develops into an elaborate system of deception which is psychologically bad for all concerned.

The plan which most workers find most satisfactory is the boarding of the baby apart from the mother. The principal difficulty here is found in the jealousy which arises between the mother and the foster mother. The child naturally becomes fonder of the one who cares for him constantly, and the bond between mother and child often becomes loosened in this way.

But to come back to public opinion, with regard to the mother, we feel that when she has been a good mother, with all that that involves in view of these monstrous handicaps, we must demand that she be accorded the respect and dignity that are her due. Has she not retrieved the past and is that not the attitude that should be expected from a Christian people? But we have every evidence that it is a very far cry from the attitude that actually does prevail among most people today. It can only be brought about by a long, careful process of intensive education.

From the standpoint of the child, what we have to consider in his separation or non-separation from his mother is the harm that may come to him with the knowledge of his illegal birth, but we must remember that this is not always overcome by adoption. What we have to cope with is the stigma as attached to the child. This seems to be founded on the principle of heredity and our best way of overcoming it is to give these children equal opportunities with other children and prove that under these circumstances they can make equally good citizens.

In the past much of our work with the children of unmarried parents has savoured too much of an unqualified acceptance of the law that the sins of the fathers must inevitably be visited on the children. But that commandment has a saving clause of mercy. What a different meaning it conveys when taken in its context, "I the Lord thy God am a jealous God visiting the sins of the fathers on the children . . . and showing mercy unto thousands." Today we feel that we have made a beginning in the right direction by bringing more of the spirit of mercy into our work by affording better social and legal protection.

In the future all that we can picture in our imagination for these children is expressed in the terms of the covenant made 1,900 years ago, "That they may have life and have it more abundantly."

[Address delivered at the fifty-first annual sessions of the National Conference of Social Work, Toronto, June 25-July 2, 1924.]

The Prevention of Endemic Goitre in New Zealand by a Public Health Nurse

By MARY LAMBIE

NEW ZEALAND consists of two long narrow islands divided into four main provincial districts; Auckland and Wellington in the north island, and Canterbury and Otago in the south. The country is very variable in type and so is the climate.

Through the medical examination of troops for overseas service during the war period, 1914-1918, it was brought to the notice of the medical authorities that a comparatively large percentage of men were being classed as unfit for service owing to an enlarged thyroid and that this was particularly apparent in men from certain districts, Canterbury being the worst. Before this period it was generally known that goitre was very common in New Zealand among women, but the knowledge that men also were largely affected, and particularly those in certain areas, was new.

Owing to the interest these statistics had caused, Dr. Hercus, who is now Professor of Public Health in the University of New Zealand, and Dr. Eleanor Baker, a school medical officer in Canterbury, were asked to make a survey of all the schools in Canterbury at the end of 1920 to ascertain the condition in that province in regard to endemic goitre among school children. The first step was the examination of all the childen in the primary schools, about forty thousand, followed by those in the high schools and training college, so that the survey covered a group in which the ages roughly extended from five years to twenty-two years.

Endemic goitre was found to be far more prevalent than had been thought. To show what had been done charts were prepared, and the goitres were classed as incipients, small, medium and large, so as to obtain a definite picture of the situation. Even among infant children, that is from five to seven years, the percentage showing some sign of enlargement was as high as fifty to sixty; while in high school the percentage of girls similarly affected was ninety-two, and of the boys, about sixty-five. One very interesting fact that became evident from these statistics was that in infant children the incidence was higher among boys than girls: the boys' line gradually dropped, until about twelve they were running even, and then, as was expected, the girls' line rapidly rose while the boys' fell, but not so much as had been thought that it would.

The facts produced were considered to be so serious that the New Zealand Health Department appropriated a certain sum of money to be spent in experimenting in the preventive treatment of endemic goitre to see what could be done.

Three large schools were selected; the parents of the children were circularized explaining what was the aim of the work and asking for the consent of the parent to allow his child to be treated at school, the treatment being absolutely free. Cards were prepared for every child in these schools, whether taking the treatment or not, as the children who were not taking it were to be used as a basis of comparison to those who were. Even in the beginning at least half consented. Every child had a complete physical examination to see that there was no reason why he or she should not take this treatment, and I may say that in a period of five years there was never a single case in which a child was upset by

it. These cards were printed so that the goitre might be entered under one of the four groups and so that they would show whether or not the child was receiving treatment. Examinations were made once a year, and the findings charted.

The treatment consisted of a small dose of iodine once a week for ten weeks in the three school terms, so that each child received thirty doses in a year. At two schools the form of iodine used was sodium iodide; the children were divided into three age groups, the youngest receiving one grain in each dose, the second group two grains, and the older children four grains. The iodine was supplied to the school in crystal form each week, when it was diluted to the correct strength. Each class had its own tray, made of wire-belting stretched over a frame in which the medicine measures sat. The teacher poured out the doses, the roll was called, and the children filed past the teacher, each child drinking its dose as it walked past. At the finish two monitors collected the medicine measures and washed and boiled them before putting them away. At the third school the dose consisted of one grain of potassium iodide in pill form for all ages; the number of doses and administration were much the same as described above. The results of this experiment were very encouraging, and it was found that the child on one grain did just as well as the one on four grains.

In 1924, a special report was prepared for the annual meeting of the British Medical Association. One of the outstanding comparisons revealed that out of a group of girls in the sixth standard—those about to enter high school—who had been under treatment for three years, only fifteen per cent. showed any sign of enlargement of the thyroid; while in a school nearby where conditions of living were similar but where the girls had not received treatment the same grade showed seventy-five per cent. having an enlargement.

This report was considered so convincing that a recommendation was passed by the British Medical Association asking the New Zealand Government to have all the table salt consumed in the country iodized before being put on the retail market. A certain section of the community, however, considered that if this were done there might be a danger of hyperthyroidism among certain individuals. In order to prove that as good results could be obtained from doses so minute that no such fear need exist two more schools were treated; in one the dose was .1 grain of potassium iodide and in the other .01 grain. During the time this experiment was carried on in the schools careful analysis of soils and vegetables grown in these soils from various parts of New Zealand was made, and it was proved that in certain districts the soil, and everything grown in it, was lacking in iodine content.

For four years I was closely connected with this work and found it intensely interesting. Perhaps the chief lesson I carried away from it was the fact that for successful statistics it is essential to chart accurately and clearly and to have large numbers of children over a long period of years, as, for various reasons, many will have to be eliminated in the final count. Without statistics our experiment would have been valueless to the general public, whom we wished to educate to see the value of iodized salt for a community so largely infected.

The following paragraph quoted from a New Zealand paper may be of interest: "In his anthropological study of the Maori people, Dr. P. Buck, director of Maori Hygiene, has discovered that they were, as a rule, free from the tendency to goitre which is now manifesting itself to a considerable extent among European

colonists. This he told the Dental Conference last week. He attributes this to a large extent to the fact that their foods contained constituents which are said to be lacking in the salt consumed by Europeans."

(**Editor's Note:** Miss Mary Lambie, of Christchurch, New Zealand, contributed the foregoing article to The Canadian Nurse. Miss Lambie was invited by the Government of New Zealand to spend the present year in Canada and the United States, where she is making a study of the work being done in nursing education, especially the courses being given to public health nurses. On Miss Lambie's return to New Zealand she will establish and become director of the course for Public Health Nurses at the National Medical University.)

The Operation and Supervision af Swimming Pools in Toronto

By J. F. HAZLEWOOD, M.B.

DURING the last ten years the general sanitation of swimming pools has been receiving an increasing amount of attention, prompted no doubt by the greater interest manifested in one of the most healthful forms of exercise.

The term "general sanitation of swimming pools" includes all those factors that may influence the health and well-being of those persons participating in the sport, and although the problem is primarily one of engineering, there are some phases of the situation which should prove of interest to the nursing profession. The object of this paper is to outline, without entering into minute detail, the methods employed at Toronto for controlling those factors.

The revised rules and regulations relative to the operation of swimming pools throughout the city endeavor to remove any conditions favorable to the propagation of disease resulting from their use, and are the outcome of those drawn up by the Local Board of Health in 1918 and the Provincial Board of Health of Ontario in 1924. They cover such ground as the design and construction of the pools, shower and dressing rooms, personal cleanliness of the bathers, ventilation and lighting, methods of keeping the water in a clean and wholesome condition, and the exclusion of all persons suspected of suffering from any communicable diseases.

Nineteen swimming pools are now in operation within the city limits, and with the exception of three, all are in use for the greater part of the year. Of the three exceptions, two are open-air pools and are in use for about three months during the summer.

As regards the design and construction of the pools in Toronto, we have both tiled and untiled and those with and without filter equipment. The advantages of a white tile lining are obvious, as any sediment that collects on the bottom of the pool is easily seen and may be quickly removed, and time and labor expended on cleaning can be cut down to a minimum. Filters attached to the pool, besides effecting a reduction in the number of bacteria, result in the saving of water by keeping it in a constant state of circulation and remove any color and turbidity that develops.

Thirteen pools are lined with tile and twelve are equipped with filters, while the remainder are merely concrete basins, coated, in most cases, with some form of concrete paint. Those pools with filter equipment are usually emptied and cleaned in periods of from three months to one year; this process is performed

weekly in the case of those lacking the filter equipment.

As a general rule, from one to two thousand gallons of fresh water are added to each pool daily, in order to remove any surface scum, make up loss from evaporation and splashing, and assist in thoroughly cleansing the scum troughs, which, in all cases save two, are placed near the normal water level of the pool and serve the double purpose of providing a place into which the bather may expectorate, and a handrail for support.

The capacities of the swimming pools vary from 15,000 to 150,000 imperial gallons, and in this connection it is important to note that the capacity has a great bearing on the control of the pool from a sanitary standpoint, with the result that the number of persons using a pool at any one time has been restricted to three per 1,000 gallons.

One might well think that all possible precautions had been taken to render the pool water almost fit for drinking purposes; this, however, is not the case, and the Department of Public Health has made it a rule, a rule which must be enforced, that available free chlorine in amounts of not less than 0.2, nor greater than 0.5 parts per million, must be present during the bathing period.

The application of some disinfectant to swimming pool water, whether filtered or unfiltered, is highly important, as the possibility of diseases of a venereal, ocular, aural or intestinal nature being transmitted from one person to another through swimming in polluted water is ever present; in fact, epidemics of this nature have been traced to this source, although the writer is not aware that such has been the case in Toronto.

Because of this the reader must not imagine that conditions in this city are ideal, for much remains to be done in this direction, and only by a most rigid enforcement of the rules and regulations, coupled with instructions of an educational nature, will perfection be even approximated.

Returning to the question of chlorination, examinations of pool waters where the process is carried out most effectively have shown that almost complete sterility may be maintained at all times by the use of chloride of lime, but as the personal factor involved is large, the Department recommends the installation of special chlorinating units to attain the desired result. The maximum number of bacteria allowed in one cubic centimetre of water examined, grown on plain agar at 37°C, has been set at 250, with, of course, the absence of Bacillus Coli in the same amount.

A great deal of emphasis must also be placed upon the preliminary cleansing of the bather's body before entering the pool. Swimming pools are not intended to be used as huge bath-tubs, and a regulation is therefore made whereby shower baths, with the use of soap, are compulsory. Strange to say, this rule seems to be observed more literally at those pools which are confined to the use of men and boys; the girls and women have formed the habit in most cases of donning a bathing suit prior to taking a shower and resent any suggestion that they reverse this rule as a reflection on their habits of personal cleanliness. It is true that most bathing at pools confined to the use of men and boys is performed in the nude, and that this may influence the result is admitted, but the fact remains that the condition of the water in the majority of the Toronto pools devoted to the use of females is generally inferior to that of the males.

Bathing suits and towels are either laundered on the premises,

sent outside for that purpose, or taken home by the individual bather. On no account should there be any possibility of an exchange of towels and bathing suits being made.

All persons who are suspected of suffering from any contagious disease are excluded from the pool, and spitting in the pool is strictly prohibited.

The Department further requires that the dressing rooms should be well lighted and ventilated, that ample lavatory accommodation be provided, and that a qualified person be in attendance at all times during the bathing period, a rule that does not receive the attention it deserves at several institutions.

In conclusion, it may be stated that education and regulation may achieve much, but if the general public using the pools demand bacteriologically clean water in which to enjoy their favorite pastime, a long step will have been taken towards the desired end, and you of the nursing profession have a great opportunity in your daily contacts of assisting in this work.

(J. F. Hazlewood, M.B., Director, Division of Laboratories, Department of Public Health, Toronto.)

Provincial District Nurses of Alberta: A Colonization Agency

By ANNIE KENNEY, Reg.N.

At present rural Alberta is the attraction of thousands of settlers and closely following the fact of this increase in population comes, obviously, the problem of keeping these people happy and well while they are becoming accustomed to their environment, or otherwise fitting themselves to become good citizens.

Naturally, the majority of these settlers locate remotely: distances from the railroad are commonly fifty to a hundred miles, over the unfinished and adventuresome roads or trails of a newly-opened country. Here is the setting of the Provincial Nurse. Well trained and carefully chosen, even carefully coached, she offers her best to the district to which she is sent. Her cottage, usually in proximity with a little store or a congenial family, soon becomes a centre of well-directed activity in public health that ought to bear fruit for decades to come.

The nurse is appointed by, and responsible to the Department of Public Health, and her work is entirely consistent with the best in modern medicine. The very practical and clearly defined duties of caring for the sick—these duties with their thousand and one opportunities for that blessed "human touch"—are easily understood and readily appreciated by these people whether of one tongue or another. Even those few settlers whose means admit of themselves going out for medical care are usually among the first, in these shut-off districts, to value the nurse as a community asset, for these people live closely in interest with one another; the welfare of one is the welfare of all, and comfort comes from the knowledge that, in an emergency, there is a helpful hand within reach kept free for them. Encouragement is also brought to the mother who, worn and weary of the struggle in its different phases, was all too resigned to the slipping away of her little one's life. Then came the nurse, strong and resistant, declaring that the little one was her child and must not, therefore, be allowed to die. A reviving draught it came to that halting mother who lifted her head and replied, "Oh, you and me! Maybe we make him live!" That mother, born in another land, accepted the incident as a form of

Canadian hospitality. She sees in the nurse a type of that nationality to which she is herself aspiring. All around her may be representatives of this country and that, but the nurse is truly all-British, all-patriotic, and (with the inevitable exceptions that only prove the rule) she is all-conforming in mind and in morals to what the country recognizes as fitting. Among these earnest, hard-working people she, in her own special and sacred trust to them of physical helpfulness, and in her intimate knowledge of their conditions and dependence, is no uncertain reality. Her worth, measurable and immeasurable, ought not to be undervalued as a colonization agency.

Address to Graduating Class

By Dr. EBERTS

We are here this afternoon to do honour to a group of nurses who have successfully concluded three year's work in the training school of this hospital. I feel sure that I shall voice the desire of this audience in extending to them congratulations and good wishes.

In accepting, as a signal honour, Miss Young's invitation to take part in this afternoon's function, I received the impression that whatever I had to say should be addressed specifically to the members of the graduating class.

During a period of thirty years' undergraduate and graduate attendance at this hospital, it has been my good fortune to have known nearly all, and to have been the friend of many, of the nurses who have passed through the training school, and I am proud to say that I know of none who has been a failure. There are certain fundamental reasons for this high standard of success, which I am confident that you, too, will attain. First and foremost, there is the original quality of mind which leads one to choose as one's vocation the profession of nursing, the keynote of which is a desire to serve. Second, the unerring judgment displayed by Miss Livingston and Miss Young in choosing the few from the many, for full vision comes only with diligence and self-denial and one may mistake one's calling. Then, while those womanly and endearing qualities which find such scope in the profession of nursing are in some measure the birthright of all women, they are possessed in fuller measure by the few. Thirdly, the sound training acquired in the wards and class rooms, the high ideals and ethical standards held up by the staff of the training school, and the enforcement of a discipline which to many a pupil nurse has proved to be, in its acceptance, the beginning of wisdom. And, lastly, the sweet lavendar of tradition, which tends to keep one's feet set aright in the path of unselfishness and public service—that tradition begotten and bequeathed by those who have laboured here before us.

Today you are enrolled in the membership of an ancient and revered profession. As to the antiquity of your calling we have no accurate knowledge, but it is safe to assume that it is as old as maternity. The art of medicine, in comparison, is but as a babe in arms. Modern nursing as you understand it, however, may be said to date from the Crimean War; and, although one may think the various and conflicting reasons voiced by historians for the Crimean War wholly inadequate, we, as members of the allied professions of medicine and nursing, have reason to give thanks for the beneficent outcome in the way of hospital and nursing reform to which it gave rise, through the advent of Florence Nightingale.

It is customary on these occasions to add something to the admonitions of your teachers, something in the way of advice. Upon what grounds can advice be offered? I should like to say something about those special virtues looked for in the trained nurse: tact, sympathy, understanding, patience, gentleness, cheerfulness and discretion, all bound together with that saving grace—a sense of humour.

Tact I purposely enumerate first, because, in spite of its supposed universality, it is often so conspicuously wanting in the young, though, indeed, it must be cultivated at all ages. Patients quickly learn to appreciate the nurse who displays tact in adequate measure, precisely at the right time.

Sympathy is the atmosphere in which many patients live and have their being. To decide how liberally it should be dispensed will often tax your judgment. But there is a special sweet sympathy which is of the heart, which blesses alike the giver and the one to whom it is given, and which is called into being in the face of those sorrows and tragedies so inevitable in the life and death of man.

Understanding comes only to those who know and love their fellow beings. What a unique opportunity the hospital wards and

the out-patient department have offered you for the study of varied types of humanity, and where better could you have learned to give rein to sympathy and human solicitude? From the babe in arms, wholly dependent upon the fostering care of the parent, to the poor old woman who shows her chronic ulcer, with countless variations in age and infirmity set between, where indeed could you have found a more fruitful soil for the growth of your understanding of life?

And with this understanding comes patience, so essential and yet so difficult to maintain in these crowded wards and clinics, where unremitting demands upon one's time and energy might well destroy the props from beneath one's temper.

Gentleness is not only lightness and deftness of the hand, but also softness and pleasantness of the voice. The heavy hand may be trained to deftness and an unsympathetic or even irritating voice may be mollified by practise, and both are to be diligently cultivated if a nurse is to attain to the highest aesthetic standing in her profession.

The indulgence of a well-balanced optimism not only brings cheerfulness to the patient, but lightens the more onerous duties of the nurse.

Within recent years specialization in medicine has appreciably thinned the ranks of the general practitioner, and in an increasing degree the role of friend, confidante and guide has been shifted to the shoulders of the nurse. Our older graduates have all acquired a regular clientele among the families in the communities they serve, and in proportion as they have displayed discretion they have become the family confidante. This honourable position carries with it grave responsibilities. I would, therefore, urge upon you the practice of reticence, as formulated in the words of Hippocrates: "Whatever in my professional practice, or even not in connection with it, I see or hear in the lives of men which ought not to be spoken of abroad, I will not divulge, deeming that on such matters we should be silent."

Finally, of these virtues one would pay a fitting homage to perhaps the greatest of all—a sense of humour. Without this it is well nigh incomprehensible how any nurse or practitioner of medicine can faithfully follow the path of duty year in and year out, without sinking into the abyss. Even in those tragic acts where pathos and melancholy would seem to hold the stage, one often unexpectedly finds a humorous note, frequently and of course unconsciously furnished by the relatives, who are prone to display a vital cleavage in views as to the gravity, from a family point of view, of an approaching end.

These virtues constitute character; and, in proportion as you practise them your characters will develop. Florence Nightingale is revered less for her concrete accomplishments in reform than for her personal character. In beauty and dignity that figure is beyond praise. Learned, observant, humane, with a profound reverence for the claims of her patients, but with an overmastering desire that her experiences should benefit others; orderly and calm, grave, thoughtful and reticent, pure of mind, Florence Nightingale will ever be the ideal nurse—a figure which has held sway in all training schools for seventy-five years, and an influence comparable only to the influence exerted by the founders of the great religions.

This leads us to a concrete philosophy of life—the philosophy that holds that one's vocation is one's religion—tersely expressed to me by an honest sailor man, who, when asked his religion, replied: "Well, sir, I was born a Catholic, but I follows the sea."

And now it is but left for me to wish you adieu and godspeed, which I do with mixed feelings of pleasure and regret: pleasure in that you should have attained the desired end; regret that some of your number at least will no longer take part in the work of this hospital. It will, no doubt, be the lot of many of you to forsake nursing for the comparative ease and security of domestic life; but, whatever fate may decree, I feel confident that your lives, enriched by your training within these walls and your acquired understanding of life—embracing the mysteries of birth and death—will not fail to be a blessing to your day and generation.

(Address by Dr. Eberts to the Graduating Class, 1925, of the Montreal General Hospital.)

(Continued from page 454)

low are liable to develop a rachitic condition, which can only be remedied by exposure to the summer sun, the quartz lamp, and by being furnished with rations previously irradiated by this means—thus ensuring the maintenance of the normal bone nutrition.

(A lecture by Dr. Macallum, Department of Biochemistry, University of Western Ontario Medical School, given before the Edith Cavell Association of London, Ont.))

The peoples who have made liberal use of milk as a food, have in contrast, attained greater size, greater longevity and have been much more successful in the rearing of their young.—E. V. McCollum.

Milk, eggs and the leafy vegetables, the protective foods, are so constituted as to correct the dietary deficiencies, of the seeds, tubers and meat.—E. V. McCollum.

Occupational Therapy

By KATHLEEN PANTON, Reg.N.

The Occupational Aides have many friends within the walls of the Hospital for Sick Children. Why? Because we recognize their worth, and we are convinced that they are highly trained and very carefully chosen. These workers are well-versed in psychology and they study the behaviour of the patients in the most astonishing way. For instance, they know the likes and dislikes of every child in the ward, and in a second they detect signs of fatigue and lack of interest, with the result that the children under guidance are always very happy.

In connection with the Neurological Clinic of our Outpatient Department, we have an observation class for atypical children. To this class come children who have become problems at home, or in the neighbourhood, or who are unable to keep up with others of their age at school. In this classroom they are first introduced—not to books and pencils and rules—but to toys and games and many delightful forms of handiwork, such as sewing, knitting, weaving, etc.

Many of these children are mentally subnormal and they will never be able to make much progress in actual book-learning, but often during their brief attendance, which is only for a few days, they demonstrate that they can be taught to do a great many useful things with their hands. If these children are trained in Occupational Therapy they may become useful and happy members of society. Throughout the Province of Ontario there are over one hundred similar auxiliary classes, forty of these being in Toronto.

Picture if you can the following types of children always to be found in our hospital:

1. The accident patient, who suddenly finds himself in a gigantic ward surrounded by strange faces and all types of illness.

2. The patient who was dangerously ill and has now wearied of hospital routine—of temperature taking, of dressing of wounds and of doctors' visits.

3. The neurological child who is mentally below par.

4. The up-patient who is so nearly normal that he finds it difficult to keep his energies in check.

For an example of this last type: A boy with an iron brace broke a window into many pieces. It was not done with malicious motive, but because he needed something to do. Another boy was asked why he wanted to make a fern basket. He answered, with a twinkle in his eye: "I want to use a hammer and nails."

Convalescence in children is always trying, as they are not able to carry on their normal activities. To them, therefore, occupational therapy is a god-send in every sense of the word.

When tools or materials with which to work are put into their hands they at once begin to live again. By this I mean that the normal working of their imagination is quickly put into play.

At our Summer Hospital on the Island wonders have been performed through the teaching of arts and craft. In fact I may add that during the season dozens of orders are taken for baskets and trays and weaving work. The patients from the Heather Club Pavilion have won great renown for this work.

I regret to say that we have an Occupational Aide for only one ward in our city hospital. Her visits are looked forward to with the greatest anticipation. Directly she makes an appearance there are cries from all corners: "May I make a basket?" or "May I make a purse?" etc., and in a short time the snapping eyes and nimble fingers are busily engaged.

(Concluded on page 476)

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
Miss AMELIA CAHILL, 723 Bloor Street, Toronto

Keeping Fit

By a Private Duty Nurse

The private duty nurse is inclined to neglect her social obligations. It is questioned if it is not possible for her to engage in more diversion of a social nature without neglecting her work. She is inclined to exclude everything else while "on a case," and her friends and relations often feel that it is useless to include her on their invitation list.

Is it any wonder that the nurse who has been engaged for some time on a case, especially on night duty, becomes—perhaps unknown to anyone but herself—irritable, listless and dissatisfied?

Any successful business man knows that frequent diversion, daily, if possible, is necessary to the success of his business, because of the buoyancy of spirit which it is necessary to maintain in order to reap the full benefit of, and enjoy his work. The mere fact of getting together at occasional luncheons or banquets contributes much to the interest of their problems, and the burden is lightened with the knowledge that it is shared.

But it is not enough for business man to meet with business man; and after the banquet, when the interests relating to their work have been discussed, the social evening is enjoyed. The wives and daughters or other lady friends are present; business topics are dropped and lighter conversation takes its place, and music, dancing or other entertainment is enjoyed. Of course there cannot be a banquet every day, but almost every business man engages in sport of some kind, or has his motor car to which with his family or other friends he can turn for diversion. But what has the private duty nurse, particularly those who live in rented rooms? If she is the only "roomer" in the house she is apt to be left to her own devices. Naturally, with little or no interest for the evening, she imagines that she is too weary for anything but to read a book or magazine and retire early, that she may be ready for the early rising and twelve hours' duty the next day. If there are two or more nurses living in the same house, their conversation is apt to relate to their cases, thus affording little opportunity for other interests.

While this condition may not exist in the larger cities where there is diversion of an entertaining nature when the day's work is done, it is certainly true of the smaller centres.

The day's work for the nurse means twelve or more hours of exacting duty, when almost every personal impulse must be smothered. She must at all times be serene and bright, that the patient's mental condition may not suffer from any cloud upon her face. She must be continually observant of the patient's condition and comfort, not only of body but of mind, while carrying out the directions of the physician. Treatments and medicines are frequently of an unpleasant nature to the patient and the nurse's resources of tact and patience are often taxed to the uttermost. She has not even the outlet to her pent-up emotions of talking to her patients of her own feelings and interests. Not only is such conversation forbidden by nursing ethics, but it would fall upon heedless or impatient ears: for the patient who is really ill, and the average convalescent, has little desire for conversation except as it re-

lates to his own condition, feelings or interests.

All of which is ample reason why it is absolutely necessary that the nurse provides, or has provided for her, pleasurable diversion after her day's work, or if on night duty, before her night's work begins.

There are very many compensations in private nursing, which have been enumerated and will be again in other articles in this section of the magazine, and the nurse has her reward in the realization that her work is useful, and is held in high honor by others; but the fact remains, and she is conscious of it, that the lack of pleasant social life in time robs her of buoyancy and sweetness, without which her work will often be drudgery and almost a spirit-breaking routine.

This may be a plea for the ten-hour day, but until that may be satisfactorily arranged, and as long as a twelve-hour day is required, surely one or two hours could frequently be allowed so that the nurse might take more part in the social life of the community and feel free to accept an invitation when it comes. For often cases are of many weeks' duration and she begins to be left out as a matter of course when social functions are planned.

At a recent luncheon held by a county medical association at which were present wives and daughters of the medical men, representatives of the hospital staff, social service workers, public health and industrial nurses, not a single private duty nurse was present or even invited! Yet to this section of the profession the discussions and addresses would have held peculiar interest, so closely is the nurse allied to the physician in his work. Without this branch of the service the physician himself admits that much of his work would be futile; and also, that there are many cases where it is nursing service that is required more than medical attention.

Now, on whom lies the blame for the oversight? As it is not within the nurse's province to censure the physician or the public, the private duty nurses must hold themselves responsible and wake up to the fact that their mistaken sense of duty to their patients and their friends is causing them to be deprived of opportunities and associations which they should claim as their own and which would contribute immeasurably to the success of their work, at the same time adding to the life of the practising nurse the stimulus she requires to enjoy life as it was meant to be enjoyed.

In the larger centres the club room, furnished by the nurses, has added much to the cheer and zest of their lives. Here they may gather with their friends and enjoy themselves according to their own particular form of entertainment. In the May number of "The Canadian Nurse" the Central Club for Nurses of New York City is described. May we hope that in the not too distant future we may see a similar club, on a smaller and less pretentious scale, in every centre where there is a registry for nurses.

The life of every man is a seamless garment; its woof his thoughts, its warp his deeds. When for him the roaring loom of time stops and the thread is broken, foolish people sometimes point to certain spots in the robe and say, "Oh, why did he not leave that out," not knowing that every action of man is a sequence from off fate's spindle.

Let us accept the work of genius as we find it; not bemoaning because it is not better, but giving.—"Little Journeys" (Jonathan Swift) —by Elbert Hubbard.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
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The Centralization of the Teaching of Student Nurses in Toronto

By E. MARION STILLWELL, Reg.N.

Prior to the recent world war, Toronto's scheme for the teaching of student nurses was similar to that in vogue in other cities. Toronto had eleven general hospitals and, in addition, several smaller private institutions. Each of these schools was conducted as a separate entity, drawing up its own curriculum and providing for the teaching of its own students.

With the advent of the war and the consequent shortage of medical men, the situation in relation to the securing of competent instructors became acute. This was more particularly true of the smaller schools. Certain of the medical men were teaching the same subjects in two, three or four schools, while other subjects were, of necessity, omitted entirely by the smaller ones. It was then that the centralized teaching scheme was inaugurated in order to conserve the time of the instructors and to cope with the needs of all the schools.

According to the original plan, which has since been amplified but never radically altered, all schools entering the scheme send their students to the University of Toronto for their lectures, since no one hospital had sufficiently large class rooms to accommodate the aggregate number of nurses. The location of the university lends itself to such a scheme inasmuch as it is centrally situated. The course of lectures is planned by the committee, composed of the superintendents of the various training schools, and called the Training School Committee. This group meets regularly and is responsible for the arrangement of the curriculum. They also meet occasionally with certain members of the faculty of the university to confer regarding the schedule. The instructors are appointed by the faculty of medicine, which chooses members from its own staff—men who are actively engaged in lecturing to the medical students and who are in touch with the most recent developments in medical science.

The majority of the schedule, particularly for the second and third years, is taught in the centralized school, although each individual school still teaches certain subjects. Hygiene and sanitation, general medicine, bacteriology, venereal diseases, psychology, and a short course in public health nursing arranged through the extension department are taught in the first year. Surgery, infectious diseases, gynecology, tuberculosis, obstetrics, orthopedic surgery, diseases of the nervous system and mental diseases follow in the second year. Pediatrics, surgical and medical emergencies, dermatology, diseases of the eye, ear, nose and throat are given in the senior year. These subjects, with the exception of chemistry, are taught under the centralized scheme at the university. Toronto has an exceptionally good technical school which offered the training schools three com-

plete courses in chemistry each year, free of charge. The laboratory facilities thus afforded so far surpassed any procurable at the university that the schools gladly availed themselves of the privilege. Chemistry and hygiene and sanitation are the only three subjects in the centralized scheme taught during the preliminary course, the remainder of the instruction during this term being given in the individual hospitals.

The examinations are set by the instructors and are the same for all the schools. The papers are read by a committee of nurses composed of representatives from the various training schools, an arrangement which again saves the time of the instructors and which does not bear heavily on any one school or person.

The expenses of the scheme are shared by all the schools according to a budget drawn up and acquiesced in by the Training School Committee. Lectures on subjects taught through the extension department of the university, for example, psychology, are paid for by the training schools. Lectures appointed by the faculty of medicine are not paid for.

As has already been stated, Toronto has eleven general hospitals. Of these but nine entered the centralized scheme at its inception. In fact, it is only during the current school year that the last of the eleven has finally entered the union. This year 750 nurses in all enjoy the privileges of the course, 300 in the first, 225 in the intermediate, and 225 in the senior years. This number, as may be expected, varies slightly from year to year.

The centralized plan has brought great development in its wake, particularly in giving the student nurses an insight into public health nursing. Stress has always been laid in the centralized scheme on this extremely important factor in the education of the nurse, the students being given six hours of lectures in the first and twenty-four hours in the senior years. Last year, however, a dream, long cherished by the Training School Committee, became at last a reality and every senior student in each hospital now receives one month actual experience in public health work, being enrolled as a university student through the extension department. Theory and practical work are planned by the department of public health nursing in the university and the practical work itself is taken in the department of public health in the city of Toronto—supervised by the university staff in the field. The course is short, but enables the schools to give each student one month's training, rather than to give a few students a longer period.

Like most plans, the centralized scheme has its disadvantages. The most outstanding of these is the fact that the students are away from the hospital a longer time than was the case formerly. This disadvantage, however, is more than compensated for by the fact that the pupils get out in the air going to and from class and are in a different atmosphere from the habitual hospital one.

Another disadvantage was the shortage of nurses on the wards, attendant on the absence of so many of the nurses at one given time. This difficulty has been obviated during the past year by a duplication of lectures, which has been made possible through the co-operation of the medical faculty. The schools have divided each of their classes into two sections, and the ward situation is no longer a problem.

The advantages are numerous, especially in the case of the smaller schools. In the first place there is better instruction in all subjects, and a uniformity in teaching which was not enjoyed formerly. In addition to this, from the standpoint of phy-

sicians and surgeons, the central teaching results in a great saving of time. Moreover the students attain a broader conception of their profession through meeting pupils from other schools, while at the same time a healthy feeling of rivalry between the schools tends to stimulate to greater intellectual activity.

Last and best, the schools derive the benefit of the direction of the university in planning the curriculum, in teaching, and in the setting of examinations. This co-operation with the university, although not a direct affiliation, is probably the most potent factor in the ultimate and necessary education of the public to regard training schools for nurses as schools of higher education rather than merely as an apprenticeship to be served. Not until such an education has been effected will there be recognized the need for separate endowments for training schools and the need for university schools for nurses: the two great goals of modern nursing education.

(E. Marion Stillwell, Reg.N., Toronto General Hospital, Toronto. Bulletin No. VI., The International Council of Nurses.)

(Continued from page 471)

This type of employment is a true antidote for pent-up surplus energy, indolence of thought and homesickness.

Due to Mrs. Loosemore's enthusiasm, we are to have in the near future our second Occupational Aide, who will be assigned to the Boys' Medical Ward, the bursary for which is being supplied by Miss Watts, of the Junior Organization of Toronto.

I sincerely hope that the day is not far off when every ward in our hospital will be so wonderfully blessed.

(Address given by Miss Kathleen Panton, Superintendent of the Hospital for Sick Children, Toronto, Ont., at the annual meeting of the Society of Occupational Therapy, held at Government House, April 30th, 1925.)

Book Review

Procedures in Nursing: Part II. By Annabelle McCrae, Instructor in Practical Nursing at the Massachusetts General Training School for Nurses. Published by E. Barrows & Co., Boston, Mass., U.S.A. Pages 527, illustrated, 12 mo. Price $1.50.

This book deals with the more advanced procedures in medical and surgical nursing and is very up-to-date, including all modern methods of treatment. The contents of the book are well arranged. Each chapter covers systematically the purpose of the treatment, equipment necessary, method of procedure, and the care of articles used in the given procedure. Procedures are given in detail, simply and clearly explained, with a number of helpful illustrations. The chapters on pre-operative and post-operative care of patients; care of patients during shock and haemorrhage; renal function tests; special treatments of eye, ear, nose and throat, and blood transfusions are well explained. The author shows an intimacy with minutest detail in each procedure, and the technique as described throughout is good. The book is a convenient size, neatly and well bound, and is provided with a satisfactory index. The print is not large, but is clear and easily read. This book should prove valuable as a text book in schools which have not their definite methods of procedure outlined, as a reference book for graduate nurses, and as a help to many instructors.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
Miss ELSIE WILSON, Prov. Dept. of Health, Winnipeg, Man.

Child Welfare in a Rural Community

By ESTHER NADEN, Reg.N.

The infant problem is as old as the human race, merely changing from generation to generation, the present problems differing greatly from those of past centuries.

Amongst the savages, when the food supply was short, all superfluous children were killed, or allowed to die of neglect. The healthy boys were usually saved, but all deformed or sickly children were sacrificed, and in some cases even healthy girl babies were exposed to death. It is only about thirty years ago that people began to realize the serious effects of the high infant mortality. The humanitarian motive was perhaps uppermost; but in some countries — France, in particular — the decline in the birth rate demanded that efforts be put forth to save all the newly born. For many generations it has been the custom to place the whole responsibility for baby care upon the individual mother. It is true that each mother must do her share, but she must have the help of the community in doing it. A pure water and milk supply, and the education of the mother in proper methods of baby care, are the responsibility of the community as a whole and not the individual mother. For many years the main cause of infant deaths has been wrong feeding, and diarrheal diseases have been the terror of infancy. The encouragement of maternal nursing, the provision of a pure or pasteurized milk supply, have reduced the death rate in communities in which they have been tried. It therefore behooves every community—rural or urban—to see that everything possible is done to reduce infant deaths from such causes.

The majority of cities have a pure water supply, and the greater part of the milk is certified or pasteurized. Little mother's leagues, pre-natal clinics, etc., have reduced materially the infant mortality in cities. It is only within recent years, however, that anyone has given thought to the mothers and babies in the country. It was generally believed that the babies in rural communities were healthier and more resistant to disease than those of the crowded cities. Fresh air, plenty of open spaces, and pure, fresh milk were supposed to give country babies a great advantage over city babies. In some of our largest cities where child welfare work has been effectively carried on the infant death rate of the poorest sections is lower than in many rural districts. Conditions in the country are not as rosy as usually pictured. The water supply is as a rule inadequate, most of the farms being supplied by their own wells. In the majority of cases these wells are poorly situated, improperly constructed, and not guarded from impurities. Flies are ever present during the summer weather and have ready access to waste products. The milk is often collected under very insanitary conditions, and left uncovered so that flies can readily infect it. Such milk is pasteurized before being used in the city, but country babies are not safeguarded in a similar manner. Fresh air and plenty of room are frequently mythical. Farm houses are often

much too small for the family, with inadequate heating and ventilation. Because the houses are difficult to keep warm during the winter the windows are seldom or never opened: thus we find a frequent cause of bronchitis and pneumonia.

In many rural districts it is almost impossible to see a doctor except at long intervals. Expectant mothers seldom consult their physicians until just before they are to be confined. Thus the babies are often born with some handicap which might have been prevented with proper prenatal care.

At first when the Cowichan Health Centre was established, bedside nursing was all that was attempted. Shortly afterwards school nursing was commenced. When in the homes attending a sick member of the family, or making home school visits, the nurses were often able to advise mothers in the care of their babies. From this beginning child welfare work has progressed until now we endeavour to visit monthly all the babies in the district. We advise the mothers in proper methods of baby care and encourage breast feeding. If for any reason breast feeding is impossible we persuade the mother to seek her doctor's advice instead of trusting to a neighbour in the important matter of a food formula. Special attention is given to the necessity for sterilizing milk, water and utensils before being used in the modification of milk.

As soon as a baby is old enough to have foods other than milk we give the mother a well-balanced diet list. This is usually appreciated as we find many mothers who think children require nothing but milk until a year old. In Cowichan we are very fortunate in having seven physicians in various parts of the district so that there are few women who are unable to see a physician at frequent intervals during their pregnancy. We have two splendid hospitals in the district and almost all obstetrical cases go to one or other of these hospitals. This of course is ideal, and we have very few maternal or infant fatalities.

Once a month we hold a well baby clinic in Duncan. The various doctors attend in turn. The clinics are held in the Women's Institute rooms and a member of the Institute serves tea to the mothers. The babies are weighed, measured, and examined by the doctor in attendance. Many mothers are in town on days other than clinic days and if they wish to weigh their babies we invite them to the Health Centre office. The baby scales are always available, even when a nurse is not present.

We are always ready to have a baby conference on the telephone, or to visit any baby at any time if an anxious mother is in trouble. Many busy mothers seldom see anyone outside their own family and are glad to have the nurse come in for a few minutes to discuss health problems with her.

[Esther Naden, Cowichan Health Centre, Duncan, B.C.]

How the Need of Maternal Care is being met in Rural Communities

By way of introduction may I quote from an article in the January edition of "The World's Health," by Sir George Newman?

"The mere increase of knowledge and particularly the knowledge of Preventive Medicine or the ways and means of personal hygiene and well-being can do nothing of itself to prevent disease and to safeguard health, unless it be understood, accepted and practised."

The question of giving adequate pre-natal advice to the woman in the rural sections during her pregnancy and care through confinement, has always been and will continue to be a difficult one to solve, and when we take into consideration the few rural communities which have a public health nurse, or are likely to have one for some years to come, we are indeed confronted with a tremendous problem.

Efforts to impart the knowledge of the Hygiene of Pregnancy and to reduce the maternal death rate have shown marked increase in the last few years both by governments and voluntary organizations, but there is still a large number of women of rural Ontario who go through their pregnancies without any medical advice or nursing care.

We are sorry to learn that of 17 countries which claim a share in western civilization, Canada is reported to have the highest maternal death rate. Just what has been the maternal mortality for the past two years in Ontario?

	Total No. of Maternal Deaths	Rate per 1000 Births
1922: Cities	178	5.5%
Towns	34	8.7%
*Rural	150	4.4%
Province	362	5.1%
1923: Cities	182	6.0%
Towns	40	8.1%
*Rural	147	4.4%
Province	369	5.2%

*Including towns of 5000 and less.

In analyzing these statistics it would appear that the maternal mortality is much higher in cities and towns where medical and nursing facilities are available than in rural sections where such facilities are not as adequate. This may be explained by the fact that many patients from the rural sections come into the city and town hospitals for attention during the period of confinement and if death occurs the death is registered in the city, though the place of residence of the individual may be many miles distant.

What is Ontario doing to combat this high maternal mortality and provide a better maternity nursing service for rural Ontario? Since 1920 public health nurses have been sent out by the Provincial Board of Health to demonstrate the importance of public health instruction and encourage municipalities to appoint permanent local nurses, to carry on a generalized public health programme—stressing the pre-natal and infant welfare work. As a result of this work, many municipalities have today public health nurses carrying on a health educational programme.

Victorian Order Nurses have been stationed for many years in towns and rural communities to provide a bedside service and establish a community health programme. This service speaks for itself and has been and still is of inestimable value to the women and children of Canada.

Following requests from the residents of rural communities in Northern Ontario, the Ontario Division of the Red Cross during the past three years has established twelve nursing outposts with a capacity of sixty-three beds and a staff of twenty-three nurses to provide nursing care for the settlers of frontier districts and outlying settlements. This experiment has received the whole-hearted support of the people of the districts as well as the Provincial Government and judging from the requests received for such Outposts the number of Outposts which could be established is limited only by the amount of money available for such a purpose. The service rendered is of two kinds.

In the one-nurse Outpost which has a capacity of one or two beds which are used for emergency cases, the nurse acts as a community nurse, making home visits and giving bedside care when necessary. In some localities the Outpost is situated many miles from a doctor and although every effort is made to put the prospective mother in touch with her physician it is sometimes impossible, for several reasons. Many of these women give a history of never having had any medical attention or nursing care during pregnancy or confinement, having depended entirely upon the help of some member of the family, neighbour or practical nurse. During the home visits the usual public health instruction is given, stressing the importance of regular visits, if possible, to the doctor; advice is given regarding the hygiene of pregnancy and the preparation necessary for confinement; also suggestions are made as to the future care of the infant. Frequently the nurse is present with the physician at the time of delivery and gives after-care each day as long as necessary. In some cases, however, it has been necessary for her to deliver the patient when it was impossible for the doctor to attend, but it is not the intention of the Red Cross to place nurses in these communities to act as midwives. It is fortunate and comforting to note that in these cases when it was impossible for the doctor to be in attendance that the maternal death rate has been nil. The reason for the non-attendance of the physician at the time of confinement may be due to the bad condition of the roads during the spring and autumn and the length of time required to cover the distance, or it may be due to the fact that many of these women are not in a financial position to pay for the service and so hesitate to call a physician.

The other type of Outpost is one in which two or three nurses are stationed, and serves as a general hospital for the community. Several beds are available for maternity cases, and as these Outposts are in localities where one or more doctors are in residence, it is always possible to have a doctor in attendance for all cases. These nurses do not do district nursing, except when hospital duties permit them to accompany the doctor to maternity cases, when requested.

A questionnaire sent to the nurses in these Outposts on "How the need of maternal care is being met in rural communities," brought very similar replies. All agreed that the greatest lack of care was in the pre-natal instruction, as practically all the women admitted to the Outposts had received no pre-natal instruction or had made no effort to get in touch with a physician before

arrangements were made for admission to hospital. Now that the Outposts are established the doctors are advising the women to come to the Outpost for confinement. Here the mother receives the necessary attention and is later taught how to properly bathe and care for her baby, and the importance of breast feeding is stressed.

The problem of domestic aid during and after confinement, which is also a serious one, has to be considered in the home where there is a large family of little children.

As a further solution to the great question of better maternal care for the women of rural Ontario the following suggestions might be considered:

(1) A physician provided by the government or voluntary agency in a locality where a doctor has been unable to procure a maintenance.

(2) More public health and Victorian Order nurses in rural communities.

(3) A visiting nurse for the community, attached to the Outpost staff.

(4) Group instruction through Home Nursing Classes.

(5) Pre-natal letters from a government agency.

(Contributed by an Ontario Red Cross Outpost Nurse.)

Records for Public Health Nursing

Part III.

By FRANCES KING

Forms Supplementing Histories and Daily Reports

Continuation Slips, for the purpose of continuing a history too long to be contained on the individual history slips, should for the most part be simple, so that the same form can be used with all types of histories. They should be of paper, 4½"x8". The top line should have spaces for surname and first name, class of history, history number, and page number. A column for dates should be ruled down the left side, and the rest of the space left for notes.

If the space provided under a heading on the individual history is not sufficient for the complete data so that a portion has to be written on a continuation slip, "Cont." and the page number should be written under the heading, so that the extra information will not be ignored and will be easy to locate.

Occasionally it is necessary to have special continuation slips, continuing some of the headings on the individual history. With the infant welfare histories, for example, may be needed a slip continuing the headings for "Feeding" and "Illness." In such a case, the continuation slip should be of the same color as the individual history sheet.

A Work Slip is really a combination memorandum and scribbling pad. If it is made 5"x8" in size, it is convenient to carry and provides plenty of space for notes. It should be carried in a loose-leaf notebook, in any order convenient to the nurse. A pocket in one cover is handy, so that the slip may be placed there out of the way after the visit has been made. It can be written in pencil. At the nurse's discretion, the notes may be written while in the home.

The design is simple so that it can be used for all sorts of problems. At the top appears the name of the family and the name or number of the nurse, and on the next line, the address and a space for the family history number. Unlike the family folder, one space is sufficient for address, as the work slip is not a permanent record and seldom has a long life. Below the address a couple of lines are left for a general statement of conditions.

As for the rest of the sheet, two date columns run down the left side. In the date column next the margin appears the day on which the next visit is scheduled. On the line with this date is a note describing the condition necessitating the visit, or the particular point which the nurse wishes to take up.

The date on which the visit is made appears in the column headed "Visit." On line with this date are entered the notes of the visit, to be used by the nurse in making her entries on the history, or in writing a report on the case.

NAME .....Nurse.....
ADDRESS .....Hist. No.....
.....

DATES Next Visit	Visit	Notes of Need and Results
.....	.....	.....
.....	.....	.....

(Work Slip, 5" across by 8" long.)

There should be a work slip for each home visited, providing a record of each visit made by the nurse. If the visit is of temporary value, not worth a history, it serves as the nurse's report to that effect to her supervisor, and can be destroyed at the supervisor's discretion. The presence or absence of a history number denotes whether or not a history is active for the case.

The work slip helps the nurse to make her history record concise and clear. At first very few people can write a report which covers the salient points without being verbose. On the work slip there is a chance to scribble informal notes which

later can be condensed and put in better order on the history.

More than this, it is a memo. which reminds the nurse while in the home of work which she has realized on previous visits needs to be done, and recalls to her mind what she taught before, so that she can follow the subject up and make sure her teaching was effective. It enables the new nurse to say: "What about that comfort Eugene was using wher Miss Predecessor was here? Burnt up?" When she gets back to the office she can make the diagonal after "Comfort" into a cross and know that something has at last been accomplished with that hopeless Onegin family.

When the family is not included in the day's visiting, the slip should be in a 5"x8" tickler file under the date the next visit is scheduled, or if no date is set, in an alphabetical file kept behind the tickler file.

If the next visit is urgent and must not be overlooked, the date under "Next Visit" may be underlined to call attention to it.

Family histories should not be taken out of the office or filed in a tickler. Since it is often necessary to refer to them in the nurse's absence, they must be kept where the supervisor can locate them readily.

A 5"x8" slip is too large to go in the family folder. So far from being a disadvantage, this is a good thing, for the work slip must never take the place of a formal record. It is easy to refer to except for recent events, while the history is a complete summary of essentials.

One danger in the use of a family folder is the tendency to drop into it all sorts of notes and papers. This should never be done. If the information is worth keeping, it should be entered at once in its proper place on the history. If it is of only temporary value, it may be noted on the work slip.

The Daily Work Report should be sufficiently comprehensive so that it can be used, not only to gauge the work of the individual nurse, but also as the basis of the report on the nurses' service to the community.

The details on a report will differ extensively according to the requirements of an organization and the locality of the work.

It is better to disassociate the amount of time the nurse spends on each piece of work from the details of the work. Let her estimate the time as closely as possible under general headings—recording, home visiting, clinic service, school service, etc., in one section of the report.

In another section, without mention of time, let her record what she did. It is not worth while to attempt any division of recording or office time. Under school service, the entries should be by name of the school served, showing the type of service rendered. The same is true of hospital and clinic service. These two services, by the way, are reported on separate statements, since only a certain number of the nurses serve in the clinics and the hospitals.

For home visiting, each visit should be shown under the name of the family, in order to check with the histories and work slips if so desired, and possibly to provide a record of the nurse's whereabouts during the day. The main reason for entering name and address, however, is that it makes it easier for the nurse to classify her visits. She remembers her work, not as problems, but as persons. As she writes the name, the work done in that home comes to mind, so that the classification of visits into problems is done accurately and easily.

No attempt should be made to record the amount of time in each home or on each class of visits. A busy nurse cannot be constantly looking at her watch and jotting down hours and minutes. If too much detail is required, the report becomes a burden, apt to be made out carelessly, and a careless guess is worse than none. If details of this kind seem imperative to the executive, they should be required for a set length of time, as a survey, and then discontinued.

To get an estimate of the average length of time spent on each class of visits is not difficult, so long as the amount of work required by the various classes is approximately similar. The following method is both simple and satisfactory.

The first step in discovering the amount of time spent on tuberculosis work, for example, is to find the percentage of the total individual visits which are tuberculosis visits. Let us say that a nurse visited 210 patients in the month, 65, or 31%, of which were tuberculosis cases.

The next step is to add together the total time spent in travel, home visiting and recording. She spent in travel 35 hours; in home visiting 70 hours; and in recording 44 hours, giving a total of 149 hours.

The percentage of visits which were tuberculosis is then applied to the total number of hours; 31% of 149 hours is 46 1-5 hours, which may be taken as the amount of time spent on tuberculosis work.

If the organization is responsible for a class of work which requires as a routine thing much more time in the home than the rest of the work, as for instance, bedside nursing, the amount of time on this one class may be required as a separate item.

(The fourth and final article will discuss the use which can be made of the various forms.)

Why Drink Milk

There is nothing "just as good as" milk.

Milk supplies some of all the material necessary for growth and also furnishes energy for work, play and warmth. It is an indispensable part of the diet of mothers who are nursing babies, and of young children. A pint and a half a day is a safe allowance of milk for an average child, while pregnant or nursing mothers, infants and many children need a qaurt of milk a day.

Milk can furnish all the protein the body needs. A quart of milk supplies as much protein as seven ounces of sirloin steak or four large eggs.

Milk supplies minerals. If the growing child does not have an abundance of minerals in his diet this deficiency may show in stunted growth, weak bones or poor teeth. Special care must be taken to select foods rich in lime, phosphorus and iron. Our bones and teeth are made largely of lime, which is a form of calcium. One quart of milk will furnish as much calcium as ten large oranges, 32 eggs or 20 pounds of beef. Milk is also a valuable source of phosphorus and supplies some iron.

The body must also be provided with certain essential substances called vitamins, if health and normal development are to be assured. All known vitamins are found in fresh milk, but one or possibly two of the vitamins may be lacking in poor, stale or heated milk.

Milk needs supplementing to supply certain minerals and vitamins in sufficient quantity and, after the early months of life, for energy and roughage. Every baby, particularly those not breast fed, should receive daily the juice of some acid fruit, such as orange or tomato. In winter, when it is impossible to be outdoors in the direct sunlight for long periods, all infants, whether nursed or atrificially fed, should be given cod-liver oil. Older children need, in addition to milk, fruit, vegetables, meat, fish or eggs, bread, cereal and potato.

Notes from the Library Committee

Personal and Community Health—

Health Confessions of Business Women by Business Women, issued free by the Division of Industrial Hygiene, Provincial Board of Health, Toronto.

Personal Hygiene for Nurses, by J. W. M. Bunker, Ph.D., and C. L. Turner, M.A.C.P.H., published by C. V. Mosby Company, St. Louis, Mo.—$2.00.

The Health Book, by Royal S. Copeland, M.D., published by Harcourt, Brace & Co., New York. A modern substitute for the old-fashioned "family doctor book."

Useful Pamphlets issued free by the Federal Department of Health, Ottawa—

Nos. 1 to 6—The Mother's Series.
Nos. 7 to 11—The Home Series.
Nos. 12 to 16—The Household Series.
Nos. 19 to 28—Series on Venereal Diseases.
Nos. 1, 17, 18—Series on Sanitation.
No. 29—Simple Goitre.
No. 30—How to Build Sound Teeth.
No. 31—What You Should Know About Tuberculosis.

Mental Hygiene—

Development in the Field of Mental Testing—Helen H. Dolan, U.S. Government Printing office, Washington —5c.

The Nervous Housewife—Dr. A. Myerson, published by Little, Brown & Co., Boston, Mass.

Tuberculosis—

Rest—a pamphlet by Dr. D. A. Stewart, Ninette Sanatorium, Ninette, Man.

Tuberculous Ulceration of the Intestines, by Dr. J. E. Pritchard, reprinted from the Canadian Medical Association Journal.

Public Health Nursing—

Helps for the Rural School Nurse, by Harriet and Hazel Wedgewood, Health Education Series No. 17, U.S. Bureau of Education, Washington—5c.

Manual of Nursing Technique, published by the Community Health Association of Boston, 502 Park Square Building, Boston—25c.

Department of Student Nurses

Convener, MISS M. HERSEY, Royal Victoria Hospital, Montreal.

An Impression

By MARY A. BIRD

"Hospital—Zone of Quiet!" How often has one hurried along with scarcely a second thought to the request of that dull brown sign. But today its message holds a new significance, and one enters respecting it, every step seeming to lift one a degree beyond the outer world of noise and confusion and rumble: to square ones shoulders just a fraction more: to set ones ideals and ambitions just a little firmer until by the time the door is reached at least the exterior is calm and controlled, though within the heart is beating a double measure.

It requires more than a little courage to "get oneself within," realizing that the closing of that door is in truth the opening to a life of broader and fuller responsibilities. One trembles just a little and wonders—"Can I meet it and live it successfully, and as I ought?" There can be but one answer—"I can, and I must!"

The office of the superintendent is reached. The very name fills one with awe and foreboding, and it is a small, though firm voice that announces the coming of another would-be-nurse into this mighty sphere. One has dreaded this moment. But why? It is a kindly smile that greets one, allaying fears, and sincere in assurance that one is facing another human being, not just a machine, a figurehead. A few necessary questions follow—answers are given, and armed with a neat handful of collars one follows to the residence, wondering to what corner of this mystery world the balance of one's uniform has wandered. More groundless anxiety! for on reaching the residence one finds the trunk already there, and the "haven of rest and study" ready for occupation.

There is still the introduction to the dining hall and its sea of strange faces, but they are a friendly, cheery group, and one soon feels "at home" among them.

In the training school one is impressed by the thoroughness, the seriousness, the splendid organization and arrangement of the work. The theoretical and practical sides are so correlated that one studies and accepts each, forming them into that greater whole almost without realization. Each task, no matter how small, is taught in the class room before performance in the ward is demanded. Methods are most thorough, and each detail is carefully explained and illustrated, so that one enters upon the practical work among the patients not with the mistaken idea of the meanness of small tasks, but rather with the knowledge that obscure tasks are but the true beginnings of greater; that the humble work of the probationer is indeed the firm foundation upon which more brilliant and advanced work is built.

And so having entered upon the probation term, one's ambitions and energies concentrate upon the winning of the coveted cap — and thoughts fly forward to graduation, that final day of honour when one feels fullest pride in one's chosen life-work.

[Mary A. Bird, Class 1928, Toronto Western Hospital.]

Canadian Army Medical Nursing Service

National Convener of Publication Committee, C.A.M.N.S.,
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Five Sisters Window—Unveiling by the Duchess of York

The restored "Five Sisters" Window, York Minster, England, was unveiled by the Duchess of York on June 24th.

The setting of the unveiling and dedication ceremony in the Minster was most harmonious and beautiful in form, sound, and color, and in its religious import. The nave and transepts, mainly the transepts, were used for the congregation and choir. The Duke and Duchess of York, with the Archbishop of York and the Dean of York (Dr. Foxley Norris) and other clergy, occupied seats on a dais on the chancel steps and in the doorway of the choir screen, and matters were so arranged that the Duchess had not to leave her place to give the signal for the unveiling. Before doing so she said:—"As an act of most high praise and glad thanksgiving to Almighty God for the lives and devotion of the 1,400 women of the Empire who died for their country in the war, now, in the name of their sisters in all parts of the world, I unveil and restore to its ancient use the Five Sisters Window." Almost immediately the curtain shrouding the window fell soundlessly and gracefully away. The perfection of the work done in restoring design and most delicate color to the ancient glass cannot be conveyed in words. It was felt to be a thing to give thanks to God for, as was done in the immediately following prayer naming "John Romain and those who labored with him in this place and enriched his work," whose inspiration and artistic endowment conceived and constructed "this great window now restored." After the singing of the hymn, "For all the saints who from their labors rest," the Archbishop dedicated the oak screen which has been erected with the surplus of the funds raised for the restoration of the window and has been placed in the St. Nicholas Chapel to bear the names of the 1,465 women whose sacrifice in the war the restoration commemorates. An anthem, "Blessed city, heavenly Salem," by the Cathedral organist, Dr. Bairstow, followed, and then came the Archbishop's address.

The service ended with the sounding of the Last Post and Reveille by the trumpeters and drums of the 8th King's Royal Irish Hussars, and the singing of the National Anthem, led by the massed bands of the Hussars, the Cheshire and the Border Regiments.

After the Minster ceremony the Duke and Duchess of York paid a visit to the Deanery, where a number of guests gathered at the invitation of the Dean and Mrs. Norris. Later the Duke of York unveiled the

York City War Memorial, a simple stone cross, mounted on a cenotaph-shaped pedestal rising from a stepped base, which has been erected by public subscription in a "Rest Park" on the banks of the River Ouse. It commemorates no fewer than 1,162 citizens of York who fell in the Great War.

Archbishop's Address

Dr. Lang said:—

"We have beheld a thing of beauty, a joy for ever, restored to the whole world. It is a true restoration: for what we now see is what our fathers saw 600 years ago. The very lead which binds the jewels of the window together is old, sent from the old Abbey of Rievaulx. By a strange romance of history and art 13th century lead has now been wedded to 13th century glass.

"Yet there is one glory added today to the great window which it never had before. Through its pure and delicate colors there now shines, and will ever shine, the light of service and self-sacrifice which ennobled the women of our land and Empire in the dark days of the Great War. Let no mists of weariness or disappointment blind our eyes to the brightness of that light. For it was indeed a noble impulse which sent forth our women and girls into varied fields of service—in hospital, in factory, on the land, in camps at the base, or at the very front of the long battle.

"The inspiration came to a woman of York now present to link the memory of these our sisters with the restoration of this famous Five Sisters Window. That flash of insight proved to be a signal which was immediately answered from every part of the Empire. Within nine weeks over 32,000 subscribers — women of every class and nation within our Commonwealth—raised the whole and more than the whole of the sum needed to restore the window. The names of the women who in every branch of national service gave their lives are graven on a screen of the Minster's own oak which surrounds the Chapel of St. Nicholas, and on which the light of the great window will ever rest. These names will thus be gathered into the rich treasure of memories which the Minster keeps secure from age to age. The old Mother will, as it were, adopt these women and girls as her own daughters, and will enfold them with her silence and her peace. The Five Sisters will keep unceasing watch over these 1,465 sisters of our race.

"Lastly, remember, we here assembled are not alone in our commemoration of them this day. Through the influence of another woman of York, at this very time remembrance is being made of them in many distant places across the seas—in South Africa, in South and West Australia, in Tasmania, in New Zealand, in Canada. The emotion which uites us here is as it were a beating of the Empire's heart."

(From The Times Weekly Edition, July 2nd, 1925.)

News Notes, C.A.M.N.S.

BRITISH COLUMBIA

A very charming tea was held on Friday afternoon, May 22nd, at the residence of Mrs. C. A. Bell, 1980 McNicol Avenue, Kitsilano, who kindly lent her home for the occasion to the Military Nursing Sisters' Club. Many of the nursing sisters and their friends were able to attend and the quarterly reunion was greatly appreciated. The friendships formed when the sisters were working together in trying times and circumstances will never be forgotten nor lightly turned aside.

ONTARIO

N/S Mabel Cudmore has joined Miss Morrison's staff as charge nurse of the surgical wards of the McKellar General Hospital, Fort William, Ont. N/S Pearl Morrison has been superintendent of this hospital for the past two years.

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News Notes

NOVA SCOTIA

The annual meeting of the Nova Scotia Graduate Nurses' Association was held at the Dalhousie Public Health Clinic on Monday and Tuesday, June 29th and 30th. There was a large attendance of members, delegates being present from the various provincial nurses' organizations.

The subjects of "Standardization of Training Schools" and "Nursing Education" received careful attention. During the past year over one thousand letters were sent to the schools of the province, outlining the educational requirements of pupils intending to take up nursing. Ways and means of providing scholarships for nurses were discussed.

On Monday evening Miss Beith read an interesting paper on the work of the Dalhousie Public Health Clinic, which gave a very definite idea of the amount of work being done by that clinic. Prof. Symonds, of Dalhousie University, gave a most interesting lecture on "Psychology" which was greatly enjoyed by all present. Refreshments were served by the Alumnae Association of the Victoria General Hospital.

Unfortunately the weather interfered with the social arrangements made for the entertainment of the visitors. However, on Tuesday evening all proceeded to the Waegwoltic Club where supper was served and an enjoyable evening spent.

HALIFAX

Miss Catherine M. Graham, Reg.N., Victoria General Hospital, Halifax, has accepted the position as matron of Rainbow Haven, the Evening Mail's Fresh Air Camp for the poor children of Halifax.

Miss Madeline Scott, Reg.N., Montreal General Hospital, 1922, has resigned her position with the Massachusetts-Halifax Health Commission at Halifax to accept a position on the staff of the E. B. Fisher Memorial Hospital, Woodstock, N.B.

The Public Health Demonstration conducted by the Massachusetts-Halifax Health Commission at Darmouth, N.S. closed May 31st, 1925.

ONTARIO

FORT WILLIAM

The account of the graduation exercises, 1925, of the McKellar Hospital, as reported in the July number, was inaccurate in regard to the number of graduates. The graduating class numbered thirteen instead of nine. The graduates received their diplomas from the president of the hospital and their pins from the superintendent of the hospital. The medals donated by the medical staff were presented by the president of the staff and awarded as follows: The gold medal to Miss Signe Berglund; silver medals to Miss Florence Dickson and Miss Eva Cliff. Two additional medals were awarded this year: one for executive ability to Miss Rheta Graham, and one for operating room technique to Miss Martha Walker.

The following are the graduates:—Florence Dickson, Dryden Ont.; Barbara Anna McQuarrie, Orangedale, N.S.; Agnes Baillie, Port Arthur, Ont.; Clara Julia Elvish, Fort William, Ont.; Rheta Sarah Graham, Owen Sound, Ont.; Mary Anne Duncan, Fort William, Ont.; Signe Carolina Berglund, Omaha, Neb.; Marjorie A. Reid, Gowganda, Ont.; Eva Irene Cliff, Fort William, Ont.; Martha Jane Walker, Aurora, Ont.; Viva Elizabeth Tate, Kemptville, Ont.; Sarah Gladys Austin, Port Arthur, Ont.; V. Leanne Guerette Michaud, Edmundston, N.B.

TORONTO

Hospital for Sick Children A.A.

A very delightful tea was given at the nurses' residence of the Riverdale Hospital by Miss Mathieson, the superintendent, and Miss Panton, superintendent of the Hospital for Sick Children, in honor of Miss Goodson and Miss Potts, former superintendents of the Hospital for Sick Children. A large number of graduates enjoyed the renewing of old friendships on the beautiful lawn of the hospital.

Miss Gertrude Spanner has resigned her position at the Civic Hospital, Ottawa, and has accepted a position at the Children's Memorial Hospital, Chicago.

A very sad accident took place on July 17th when Mrs. Emmet (Effie Cook, 1913), wife of Dr. Emmet of Ponthill, Ont., lost her life when swimming. Her husband, two little children, and a host of friends mourn her untimely death.

Toronto General Hospital A.A.

On Wednesday, July 16th, a garden party and dance were held on the grounds of the nurses' residence, Toronto General Hospital, to raise funds for the library and also to finance the sending of student nurse delegates to the Student Christian Movement at Elgin House. A great deal of ingenuity was shown in the preparation

of the various booths which were the attraction of the evening. A marcelling and manicuring parlour; a shoe shine stand; a bureau of health; a touch and take tree; a fortune telling booth and a tea garden, all plied their trades busily throughout the evening, which was most enjoyable and successful, netting the student nurses about four hundred dollars.

Miss G. McCullough, 1922, was at Orangeville Hospital for the month of August, relieving during the superintendent's absence.

Miss Agnes Campbell, 1923, has left for Chicago to do institutional work in the Illinois Central Hospital.

Miss Agnes MacKenzie, 1923, is camp nurse at Camp Tanamakoon, Algonquin Park, for the summer. She is enjoying the life very much and up to date her duties have not been too arduous—mostly attention to fly and mosquito bites and one sprained ankle.

Miss E. Maude Owen, 1923, has accepted a position as supervisor in the City Hospital, Youngstown, Ohio.

BIRTHS

BENNETT—On July 20th, 1925, at The Wellesley Hospital, Toronto, to Mr. and Mrs. Bennett (Olive Bennett, Wellesley Hospital, 1922), a son.

BRIGHT—On May 25th, 1925, at Oshawa General Hospital, to Mr. and Mrs. H. Royston Bright (Gladys Fairclough, Wellesley Hospital, Toronto, 1920), of Myrtle Station, Ont., a son (John David).

BROWN—On July 14th, 1925, at Brighton, Sussex, England, to Flight-Lieut. and Mrs. L. L. Brown (D. M. Moore, Winnipeg General Hospital, 1917), a son (Charles Jewell).

GITTENS—On May 21st, 1925, at Vancouver General Hospital, to Mr. and Mrs. John R. Gittens (Cicilia Gibson, Vancouver General Hospital, 1914), twin sons.

McKERRACHER—In May, 1925, to Mr and Mrs. McKerracher, 131 Woodbine Ave., Toronto, a son (Hugh).

STEELE—On June 28th, 1925, at The Wellesley Hospital, Toronto, to Mr. and Mrs. H. L. Steele (Gladys Bateman, Wellesley Hospital, Toronto, 1916), a son.

WATT—On July 27th, 1925, at the General Hospital, Crossett, Ark., U.S.A., to Mr. and Mrs. Jas. W. Watt (E. Maude Mosher, Victoria General Hospital, Halifax, N.S.), a son (George Benvie).

MARRIAGES

FULLER—PRINGLE—On August 1st, 1925, Marguerite Pringle (Wellesley Hospital, Toronto, 1922), to G. B. Fuller, of Wilkinsburg, Pa.

KILTY — CHISHOLM — On June 14th, 1925, at Oakville, Justina Chisholm (H.S.C., Toronto, 1923), to George Kilty, of Clinton, Ont.

McDOWELL—CAPLING—On July 10th, 1925, at St. Paul's Cathedral, Toronto, Florence Capling (Toronto General Hospital, 1921), to Frank McDowell.

PATTERSON—FRASER—On July 27th, 1925, Laura G. Fraser (Saskatoon City Hospital, 1919), to Dr. Cecil F. Patterson, of the University of Saskatchewan. Dr. and Mrs. Patterson will reside at 913 Temperance St., Saskatoon, Sask.

WOODROW — WHITFIELD — On July 28th, 1925, at Dunn Ave. Methodist Church, Toronto, Mildred A. Whitfield (Wellesley Hospital, Toronto, 1922), to Dr. Walter H. Woodrow, of Detroit, Mich.

DEATHS

EMMET—On July 17th, Mrs. Emmet (Effie Cook, Hospital for Sick Children, Toronto, 1913), wife of Dr. Emmet, of Ponthill, Ont., who lost her life when swimming.

LAIRD—On July 17th, at her brother's home in Westmount, Bessie P. Laird, (Toronto General Hospital, 1918).

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OCTOBER, 1925

CONTENTS **PAGE**

REPORT OF THE CONGRESS, 1925: INTERNATIONAL COUNCIL OF NURSES - - - - - *Jean E. Browne, Jean I. Gunn* 513

FOREST SCHOOLS IN TORONTO - - - - - *Anna G. Dove* 524

DEPARTMENT OF PRIVATE DUTY NURSING:
NURSING AS A PROFESSION - - *Annie E. McIntyre* 526
REPORT OF EXTENSION COURSE FOR PRIVATE DUTY NURSES- - - - - - - - - - - 527

DEPARTMENT OF NURSING EDUCATION:
THE VALUE OF THE CLINIC IN THE EDUCATION OF THE NURSE - - - - - - - *Lilian Laurie* 529

DEPARTMENT OF PUBLIC HEALTH NURSING:
CHILD PSYCHOLOGY - - - - - - - - - - 533
PUBLIC HEALTH NURSING RECORDS: PART IV *Frances King* 535

DEPARTMENT OF STUDENT NURSES:
WITH THE VICTORIAN ORDER OF NURSES *Katherine E. Beattie* 536

CANADIAN ARMY MEDICAL NURSING SERVICE:
WITH THE CANADIAN RED CROSS IN PICTOU COUNTY - - - *N/S. Marguerite O. Gray* 537
THE ARMY NURSING SERVICE - - *Maude E. Wilkinson* 538

NEWS NOTES - - - - - - - - - - - - 540

OFFICIAL DIRECTORY - - - - - - - - - - 547